

<i>SERFF Tracking Number:</i>	<i>HARL-126109594</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Hartford Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42155</i>
<i>Company Tracking Number:</i>	<i>GBD-1200_GCF_2009_04</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.005 Combined Short Term and Long Term</i>
<i>Product Name:</i>	<i>GCF_AR_HL_DI_GBD-1200 B.4 Edu_2009 Enhs IV</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Hartford Life Insurance Company

Product Name: GCF\_AR\_HL\_DI\_GBD-1200 B.4 Edu\_2009 Enhs IV  
 SERFF Tr Num: HARL-126109594 State: ArkansasLH

TOI: H11G Group Health - Disability Income	SERFF Status: Closed	State Tr Num: 42155
Sub-TOI: H11G.005 Combined Short Term and Long Term	Co Tr Num: GBD-1200_GCF_2009_04	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Yolanda Topps, Faristine Moore, Mattie Fagan, Kathie Read	Disposition Date: 05/11/2009
	Date Submitted: 04/20/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 01/07/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Association
Filing Status Changed: 05/11/2009	Explanation for Other Group Market Type:
	State Status Changed: 05/11/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

We are submitting the enclosed modules for general use with our Certificate Form GBD-1200 A.1 et al. previously approved by your Department on November 5, 2003. A list of modules included in this filing is enclosed for your convenience.

The modules include revisions of language previously filed and approved by your department as well as ten modules

SERFF Tracking Number: HARL-126109594 State: Arkansas  
Filing Company: Hartford Life Insurance Company State Tracking Number: 42155  
Company Tracking Number: GBD-1200\_GCF\_2009\_04  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: GCF\_AR\_HL\_DI\_GBD-1200 B.4 Edu\_2009 Enhs IV  
Project Name/Number: /

describing new definitions or benefits. These modules do not replace any modules currently on file with your department.

See see the cover letter included with this filing.

## Company and Contact

### Filing Contact Information

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200 Hopmeadow St.  
Simsbury, CT 06089  
Faristine.Moore@hartfordlife.com  
(860) 843-8259 [Phone]

### Filing Company Information

Hartford Life Insurance Company  
200 Hopmeadow Street  
Simsbury, CT 06089  
(860) 547-5000 ext. [Phone]  
CoCode: 88072  
Group Code: 91  
Group Name:  
FEIN Number: 06-0974148  
State of Domicile: Connecticut  
Company Type: Life  
State ID Number:

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life Insurance Company	\$50.00	04/20/2009	27273125

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/11/2009	05/11/2009

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*Project Name/Number:*      /

## **Disposition**

Disposition Date: 05/11/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Product Name: GCF\_AR\_HL\_DI\_GBD-1200 B.4 Edu\_2009 Enhs IV  
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variable Language	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	List of Modules	Approved-Closed	Yes
Form	Schedule of Insurance	Approved-Closed	Yes
Form	Any Occupation	Approved-Closed	Yes
Form	Current Monthly/Weekly Earnings	Approved-Closed	Yes
Form	Calculation of Monthly Benefit: Return to Work Incentive	Approved-Closed	Yes
Form	Termination of Benefit Payment	Approved-Closed	Yes
Form	Family Care Credit Benefit	Approved-Closed	Yes
Form	Survivor Income Benefit	Approved-Closed	Yes
Form	Workplace Modification Benefit	Approved-Closed	Yes
Form	Felonious Assault Benefit	Approved-Closed	Yes
Form	Occupational/Non-Disabling Felonious Assault Benefit	Approved-Closed	Yes
Form	Medical Premium Supplement Benefit	Approved-Closed	Yes

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TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: GCF\_AR\_HL\_DI\_GBD-1200 B.4 Edu\_2009 Enh's IV

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## Form Schedule

**Lead Form Number:** GBD-1200 B.4 Edu

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GBD-1200 B.4 Edu	Schedule Pages	Schedule of Insurance	Initial			B4 Schedule Edu.pdf
Approved-Closed	GBD-1200 C05 Edu	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Any Occupation	Initial			C05 Any Occ Edu.pdf
Approved-Closed	GBD-1200 C09 (Rev.)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Current Monthly/Weekly Earnings	Initial			C09 Current Monthly Weekly Earnings.pdf
Approved-Closed	GBD-1200 F12 Edu	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Calculation of Monthly Benefit: Return to Work Incentive	Initial			F12 RTW Incentive Edu.pdf
Approved-Closed	GBD-1200 F18 Edu	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Termination of Benefit Payment	Initial			F18 Termination Edu.pdf
Approved-Closed	GBD-1200 F25 Edu	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Family Care Credit Benefit	Initial			F25 Family Care Edu.pdf

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Approved- Closed	GBD-1200 F27 Edu	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Survivor Income Benefit	Initial	F27 Survivor Income Edu.pdf
Approved- Closed	GBD-1200 F29 Edu	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Workplace Modification Benefit	Initial	F29 Workplace Mod Edu.pdf
Approved- Closed	GBD-1200 F45	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Felonious Assault Benefit	Initial	F45 Felonious Assault.pdf
Approved- Closed	GBD-1200 F46	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Occupational/Non- Disabling Felonious Assault Benefit	Initial	F46 Occ-Non- Disabling Felonious Assault.pdf
Approved- Closed	GBD-1200 F47	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Medical Premium Supplement Benefit	Initial	F47 Medical Prem Supp.pdf



## [Schedule of Insurance]

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered Injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

**The benefits described herein are those in effect as of [DATE].**

### **Cost of coverage:**

You [must/do not] contribute toward the cost of coverage.

**Eligible Class(es) for Coverage:** All [Full-time] [and Part-time] Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time	[at least # hours weekly]
Employment:	
Part-time	[at least # hours weekly [, but less than # hours
Employment:	weekly]]

[Annual Enrollment Period: [MONTH & DAY] through [MONTH & DAY] [As determined by Your Employer on a yearly basis]]

**[Maximum Monthly Benefit:** [\$[XXXXXXXX]]

**[Guaranteed Issue Amount:** [\$[XXXXXXXX]]

**[Minimum Monthly Benefit:** [[X] % of the Monthly Benefit before the deduction of Other Income Benefits.] [The greater of:

- 1) \$[X]; or
- 2) [X]% of the Monthly Benefit before the deduction of Other Income Benefits].]

### **[Initial Benefit Period Percentage:**

Option 1: [X]%  
Option 2: [X]%

### **Continuing Benefit Period Percentage:**

Option 1: [X]% of Pre-Disability Earnings  
Option 2: [X]% of Pre-Disability Earnings]

### **Eligibility Waiting Period for Coverage:**

Option 1: [X] day(s) - if You are working for the Employer on The Policy Effective Date; or  
Option 2: [X] day(s) - if You start working for the Employer after The Policy Effective Date.]  
[You will be eligible for coverage on the first day of the month on or next following the date on which You complete the Eligibility Waiting Period for Coverage.]

[The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer in an eligible class under the Prior Policy.]

### **Elimination Period:**

[For Disability caused by Injury, benefits commence on the [X] consecutive day of Disability]  
[For Disability caused by Sickness, benefits commence on the [X] consecutive day of Disability]  
[For Disability caused by Sickness or Injury, benefits commence on the [X] consecutive day of Disability.]

[For Elimination Periods of [30] days or less, benefits commence on the first day of hospital confinement for hospital confinements of 24 hours or more.]]

[Schedule of Insurance

[For Disability caused by [Injury][Sickness][Injury and Sickness]:]

**[Maximum Duration of Benefits Table**

<b>Age When Disabled</b>	<b>Benefits Payable</b>
Prior to Age 62	To Age 65, or for 48 months, if greater
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months]

[For Disability caused by [Injury][Sickness][Injury and Sickness]:]

**[Maximum Duration of Benefits Table**

<b>Age When Disabled</b>	<b>Benefits Payable</b>
Prior to Age 65	60 months
Age 65-69	To Age 70, but not less than 12 months
Age 69 and over	12 months]

]

Any Occupation

means any occupation for which You are qualified by education, training or experience [and that has an earnings potential greater than [the Maximum Monthly Benefit] [the lesser of:

- 1) [the product of Your Indexed Pre-Disability Earnings] [and 80%]; or
- 2) [the Maximum Monthly Benefit]].

GBD-1200 C05 Edu

**[Current  
[Monthly/Weekly]  
Earnings**

means [Monthly/Weekly] earnings You receive from:

- 1) [the Employer; and
- 2) other employment;]

while You are Disabled [and eligible for the Disabled and Working Benefit.]

[However, if the other employment is a job You held in addition to Your job with the Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly/Weekly] Earnings.]

[Current [Monthly/Weekly] Earnings also includes the pay You could have received for another job or a modified job if:

- 1) such job was offered to You by the Employer, or another employer, and You refused the offer; and
- 2) the requirements of the position were consistent with:
  - a) Your education, training and experience; and
  - b) Your capabilities as medically substantiated by Your Physician.]

[Current [Monthly/Weekly] Earnings do not include earnings from work performed prior to the Date of Disability.]]

**Calculation of  
Monthly Benefit:  
Return to Work  
Incentive: How are  
my Disability benefits  
calculated?**

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 12 consecutive months by deducting Other Income Benefits from the Maximum Benefit.

Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

- 1) the day You first start work; or
- 2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit by deducting Other Income Benefits and Your Current Monthly Earnings from the Maximum Monthly Benefit. The result is Your Monthly Benefit.

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**Termination  
of Benefit**

**Payment:**

*When will my  
benefit  
payments  
end?*

Benefit payments will stop on the earliest of:

- 1) the date You are no longer Disabled;
- 2) the date You fail to furnish Proof of Loss;
- 3) [the date You are no longer under the Regular Care of a Physician [, unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You]; ]
- 4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;]
- 5) the date of Your death;
- 6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;]
- 7) [the last day benefits are payable according to the Maximum Duration of Benefits Table or;]
- 8) [the date Your Current Monthly Earnings exceed:
  - a) [80]% of Your [Indexed] Pre-Disability Earnings if You are receiving benefits for being Disabled from Your Occupation [or a Reasonable Alternative]; or
  - b) [80]% of Your Indexed Pre-Disability Earnings if You are receiving benefits for being Disabled from Any Occupation;]]
- 9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;
- 10) [the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
  - a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
  - b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
  - c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
  - d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;]provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation;] or
- 11) [the date You receive retirement benefits from any employer's Retirement plan, unless:
  - a) You were receiving them prior to becoming Disabled; or
  - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]

**Family Care Credit**

**Benefit:** *What if I must incur expenses for Family Care Services in order to participate in Rehabilitation?*

If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

- 1) Family Care means the care or supervision of:
  - a) Your children under age [13]; or
  - b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
- 2) the Maximum Monthly deduction allowed for each qualifying child or family member is:
  - a) [\$200] during the first [6] months of Rehabilitation; and
  - b) [\$X] thereafter;but in no event may the deduction exceed the amount of Your Current Monthly Earnings;
- 3) Family Care Credits may not exceed a total of [\$2,500] during a calendar year;
- 4) the deduction will be reduced proportionally for periods of less than a month;
- 5) the charges for Family Care must be documented by a receipt from the caregiver;
- 6) the credit will cease on the first to occur of the following:
  - a) You are no longer in a Rehabilitation program; or
  - b) Family Care Credits for [12] months have been deducted during Your Disability; and
- 7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly [Benefit]. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed [80%] of Your [Indexed] Pre-Disability Earnings.

**Survivor Income Benefit:** *Will my survivors receive a benefit if I die while receiving Disability Benefits?*

If You were receiving a Monthly [Disability] Benefit at the time of Your death [and You had been receiving such benefits [for at least 12 months]], We will pay a [Survivor Income Benefit] when We receive proof satisfactory to Us:

- 1) of Your death; and
- 2) that the person claiming the benefit is entitled to it.

[We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.]

[We will pay the Survivor Income Benefit:

- 1) [to the beneficiary You designated; or
- 2) if no beneficiary has been designated:]
  - a) to Your Surviving Spouse; or
  - b) if no Surviving Spouse, in equal shares to Your Surviving Children;
  - c) [if no Surviving Spouse or Surviving Children, to Your estate.]]

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

[The Survivor Income Benefit is calculated as [3] times the [Maximum] Monthly Benefit.]

[To designate or change Your designation of beneficiary, You must file a written notice with Us on any form satisfactory to Us. Whether You are living or not, any change will relate back and take effect as of the date You signed the written notice. We are not liable for payment of benefits made before receiving written notice.]

**Surviving Spouse** means Your wife or husband who was not legally separated or divorced from You when You died. ["Spouse" will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to Us, establishing that You and Your partner are domestic partners for purposes of this Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.]

**Surviving Children** means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance [and who are:

- 1) under age 19; or
- 2) [between the ages of [19 and 23], inclusive, and in full-time attendance at an institution of learning].

The term Surviving Children will also include any other children related to You by blood or marriage [or domestic partnership] and who:

- 1) lived with You in a regular parent-child relationship; and
- 2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

**[Workplace  
Modification**

**Benefit:** *Will the  
Rehabilitation  
program provide for  
modifications to my  
workplace to  
accommodate my  
return to work?*

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee.

You qualify for this benefit if:

- 1) Your Disability is covered by this Policy;
- 2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
- 3) We approve, in writing, any proposed Workplace Modifications.

[Benefits paid for such workplace modification shall not exceed [the lesser of:

- 1) [\$X]; or]
- 2) [[1,2,3] times Your Maximum Monthly Benefit, before any deduction for Other Income Benefits.]]

We have the right, at Our expense, to have You examined or evaluated by:

- 1) a Physician or other health care professional; or
- 2) a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

- 1) the proposed modifications made on Your behalf are complete;
- 2) We have been provided written proof of the expenses incurred to provide such modification; and
- 3) You have returned to work as an Active Employee.

**Workplace Modification** means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this Policy.]

**Felonious Assault****Benefit:**

*When is the Felonious Assault Benefit payable?*

If You [or Your Spouse] become [Totally] Disabled as the result of a Felonious Assault which occurs while covered under The Policy, We will pay an additional Felonious Assault Benefit. This benefit will be paid:

- 1) [following the greater of a [60] day waiting period or the [Totally] Disability Benefit Waiting Period;]
- 2) in a lump sum.

For the purposes of this benefit, the term Felonious Assault means an act which:

- 1) [is an attempt to cause bodily injury; or
- 2) purposely, knowingly, and recklessly causes bodily injury; or
- 3) negligently causes bodily injury with a deadly weapon;]

and is directed at You [or Your Spouse] during the course of a robbery, kidnapping or other criminal assault.

Such assault must be reported to police and filed in a police report within [72] hours of the act and You [or Your Spouse] must become [Totally] Disabled as a result of the assault.

[The specific amount(s) for this benefit are shown in the Schedule of Insurance.]

This benefit will not pay for an Injury that results from a Felonious Assault committed by:

- 1) a member of [the Insured Person's family;]
- 2) a member of the household in which [the Insured Person lives];
- 3) [the Insured Person's fellow [Employee]].

**[Occupational] [Non-Disabling] Felonious Assault Benefit:**

*When is the [Occupational] [Non-Disabling] Felonious Assault Benefit payable?*

If You sustain an Injury:

- 1) as a result of a Felonious Assault which occurs while covered under The Policy; and
- 2) as an [Employee] engaged [Full-time] in Your [normal and customary] occupation during:
  - a) regularly scheduled working hours; [or
  - b) a required period of work not coinciding with regular work hours;] [or
  - c) while in transit to or from work],

We will pay an additional [Occupational] [Non-Disabling] Felonious Assault Benefit. This benefit will be paid in a lump sum.

For the purposes of this benefit, the term Felonious Assault means an act which:

- 1) [is an attempt to cause bodily injury; or
- 2) purposely, knowingly, and recklessly causes bodily injury; or
- 3) negligently causes bodily injury with a deadly weapon;] and

is directed at You during the course of a robbery, kidnapping or other criminal assault.

Such assault must be reported to police and filed in a police report within [72] hours of the act.

[The specific amount(s) for this benefit are shown in the Schedule of Insurance.]

This benefit will not pay for an Injury that results from a Felonious Assault committed by:

- 1) a member of [the Insured Person's family];
- 2) a member of the household in which [the Insured Person lives];
- 3) [the Insured Person's fellow [Employee]].

**Medical  
Premium  
Supplement  
Benefit:**

*Does The Policy  
also cover  
premium  
contributions for  
continuance of  
Medical  
coverage?*

If You:

- 1) become Disabled while You are covered under this Medical Premium Supplement Benefit;
- 2) are receiving a Monthly Benefit under The Policy; and
- 3) [have experienced a COBRA qualifying event and have elected COBRA continuance of [Your Employer's] Medical Plan] [are an active participant in [Your Employer's] Medical Plan] on the date you become Disabled and incur out-of-pocket expenses as a result of Your election to continue coverage under that Medical Plan;
- 4) have not had a lapse in Your [COBRA coverage] [coverage under [Your Employer's]] Medical Plan during the elimination period; and
- 5) are not eligible for Medicare,

We must pay a [Monthly] [semi-monthly] Medical Premium Supplement Benefit to [You] [[Your Employer] on Your behalf.] The Medical Premium Supplement Benefit will be [the lesser of]:

- 1) [\$[X] per month] [;or]
- 2) the actual amount of premium You pay to [Your Employer] to continue coverage [under Your Medical Plan] [pursuant to COBRA].

You will cease to receive a Medical Premium Supplement Benefit when:

- 1) You cease to be Disabled; [or]
- 2) You have received payments under this benefit for [X months;]
- 3) [Your coverage under [Your Employer's] Medical Plan ends due to Your failure to pay premiums for that coverage;]
- 4) [COBRA continuance under [Your Employer's] Medical Plan ends for any reason;]
- 5) You fail to provide satisfactory proof [on a quarterly basis] that You are making premium payments to [Your Employer] for [COBRA] continuation of Your Medical Plan;
- 6) You obtain coverage for Yourself [or Your dependents] under another group Medical Plan; [or]
- 7) The Policy terminates].

**COBRA** means the Consolidated Omnibus Reconciliation Act of 1985, as amended, including changes made by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Medical Plan** means a program that:

- 1) provides health insurance or medical coverage to Your [and Your dependents]; and
- 2) for which You are eligible as a result of employer with [the Employer].

Medical Plan does not include:

- 1) [coverage for Your dependents];
- 2) accident-only or disability income insurance;
- 3) [limited scope,] [dental,] [vision,] benefits;
- 4) long term care/nursing home care/home health care coverage or any combination thereof;
- 5) Medicare supplemental coverage;
- 6) Specified disease coverage;
- 7) Hospital confinement indemnity insurance; or
- 8) Other similar types of insurance coverage designed to provide limited, incidental or supplemental benefits.

[Payment of the Medical Premium Supplement Benefit will not result in any reduction of Your Monthly Benefit.] [If the sum of Your Monthly Benefit, Current Monthly Earnings, if You are not receiving benefits under the Return to Work Incentive, and the Medical Premium Supplement Benefits exceeds 100% of Your [Indexed] Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess.] [However, Your

Monthly Benefit will not be less than the Minimum Monthly Benefit.]

This benefit is subject to all other applicable terms and conditions of The Policy.

If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Medical Premium Supplement Benefit for each day You were Disabled.

GBD-1200 F47

<i>SERFF Tracking Number:</i>	<i>HARL-126109594</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Hartford Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42155</i>
<i>Company Tracking Number:</i>	<i>GBD-1200_GCF_2009_04</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.005 Combined Short Term and Long Term</i>
<i>Product Name:</i>	<i>GCF_AR_HL_DI_GBD-1200 B.4 Edu_2009 Enhls IV</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: HARL-126109594 State: Arkansas  
Filing Company: Hartford Life Insurance Company State Tracking Number: 42155  
Company Tracking Number: GBD-1200\_GCF\_2009\_04  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: GCF\_AR\_HL\_DI\_GBD-1200 B.4 Edu\_2009 Enh's IV  
Project Name/Number: /

## Supporting Document Schedules

**Review Status:**  
**Satisfied -Name:** Flesch Certification Approved-Closed 05/11/2009

**Comments:**

Although this filing does not include a policy or certificate, we have reviewed Rule & Regulation 19 for Unfair Sex Discrimination in the Sale of Insurance, Rule & Regulation 49 with regard to the Accident and Health Guaranty Association and Bulletin 11-88 requiring a Consumer Notice. We comply with the requirements of each.

Attached is the required Certification of Readability (Flesch Certification).

**Attachment:**

4-6-09 CERT OF READABILITY\_HL.pdf

**Review Status:**  
**Bypassed -Name:** Application Approved-Closed 05/11/2009

**Bypass Reason:** Not applicable to this filing.

**Comments:**

**Review Status:**  
**Satisfied -Name:** Statement of Variable Language Approved-Closed 05/11/2009

**Comments:**

Statement of Variability as required in the General Instructions and in a separate document, the corresponding modules with the instances of variability indicated.

**Attachments:**

SOVL Spreadsheet.pdf

GBD-1200 B.4 Schedule Edu et al.\_SOVL.pdf

**Review Status:**  
**Satisfied -Name:** Cover Letter Approved-Closed 05/11/2009

**Comments:**

Please see the attached cover letter describing this filing.

**Attachment:**

4-20-09\_AR Cover Letter\_HL.pdf

*SERFF Tracking Number:*      *HARL-126109594*                      *State:*                      *Arkansas*  
*Filing Company:*              *Hartford Life Insurance Company*              *State Tracking Number:*      *42155*  
*Company Tracking Number:*      *GBD-1200\_GCF\_2009\_04*  
*TOI:*                      *H11G Group Health - Disability Income*              *Sub-TOI:*                      *H11G.005 Combined Short Term and Long Term*  
*Product Name:*              *GCF\_AR\_HL\_DI\_GBD-1200 B.4 Edu\_2009 Enhs IV*  
*Project Name/Number:*      /

**Satisfied -Name:**      List of Modules                      **Review Status:**                      Approved-Closed                      05/11/2009

**Comments:**

Please see the attached list of the modules included with this filing for review and approval.

**Attachment:**

Modules List.pdf

**CERTIFICATION OF READABILITY**  
**HARTFORD LIFE INSURANCE COMPANY**

Certification of Readability for modules GBD-1200 B.4 Edu et al., which will be used in conjunction with group disability income certificate form GBD-1200 A.1 et al.

Form GBD-1200 B.4 Edu et al.: 50.2

We hereby certify that the following modules meet the minimum Flesch Reading Ease Base Score.

GBD-1200 B.4 Edu	GBD-1200 F27 Edu
GBD-1200 C05 Edu	GBD-1200 F29 Edu
GBD-1200 C09 (Rev.)	GBD-1200 F45
GBD-1200 F12 Edu	GBD-1200 F46
GBD-1200 F18 Edu	GBD-1200 F47
GBD-1200 F25 Edu	



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Dana MacKinnon  
Vice President

April 6, 2009

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Date

Statement of Variable Language					
Group Disability Income Insurance					
Form GBD-1200 A.1					
Introduction: This statement of variable material (SOVL) shows the language we intend to substitute, delete or change. Variable language is identified by brackets ([ ]) in each module of Form GBD-1200. Each module is identified in this SOVL and each variable within each module is numbered on the form. These numbers directly correspond with the numbers on the SOVL for the appropriate module.					
<b>Constant Variables</b>					
1	Wherever the term "the Employer" appears, it may be changed to "Your employer" or some other term to accommodate non-Employer groups				
2	Wherever the term "Employee" appears, it may be changed to "Member" or "Associate" or "Insured Person" or some other term, to reflect the case specifics				
3	Wherever the term "Policyholder" appears, it may be changed to "Employer" or "Organization" or some other term to reflect the case specifics				
4	Wherever "Monthly/Weekly" appears, one or the other term will be used, not both, to reflect the case specifics				
5	Wherever a reference to "Your Spouse" appears, it may be deleted if Spouse Disability coverage not offered; if that is the case, all other references will agree with no spouse coverage offered (eg. he or she deleted)				
6	Wherever the word "Policy" appears, it may be replaced by "Plan" or some other term to accommodate the structure of the Policyholder				
7	Hartford Life [and Accident] Insurance Company may be Hartford Life Insurance Company				
Page #	Module #	Description	Variable #	Description of Variables	Use
Form GBD-1200 B.4 Edu	n/a	Schedule of Insurance		Language on page is illustrative.	
	GBD-1200 C05 Edu	Any Occupation	1	Entire section may be deleted; item 1 and/or item 2 may be deleted.	
			2	Maximum Monthly Benefit may be shown here.	
			3	May be deleted.	
			4	May be deleted.	
			5	May be 50% - 80%.	
			6	Maximum Monthly Benefit may be shown here.	
	GBD-1200 C09 (Rev.)	Current Monthly/Weekly Earnings			
			1	Entire section may be deleted.	
			2	Either item may be deleted.	
			3	Either item may be deleted.	
			4	Either item may be deleted or may show other source of income such as "Your law practice."	
			5	May be deleted.	
			6	May be deleted.	
			7	May be 6 - 24 months.	
			8	Either item may be deleted.	
			9	Entire section may be deleted.	
			10	Either item may be deleted.	
			11	May be deleted.	
			12	Either item may be deleted.	

Page #	Module #	Description	Variable #	Description of Variables	Use
	GBD-1200 F18 Edu	<b>Termination of Payment:</b> <i>When will my benefit payments end?</i>	1	May be deleted.	
			2	May be deleted.	
			3	May be deleted.	
			4	May be deleted.	
			5	May be deleted.	
			6	All of item 8 may be deleted; item a or item b may be deleted.	
			7	May be 60% - 100%.	
			8	May be deleted.	
			9	May be deleted.	
			10	May be 50% - 80%.	
			11	May be deleted.	
			12	May be deleted.	
	GBD-1200 F25 Edu	<b>Family Care Credit Benefit:</b> <i>What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?</i>	1	May be 10 - 16.	
			2	May be \$100 - \$800	
			3	May be 6 months - 12 months.	
			4	May be \$100 - \$400.	
			5	May be \$2,500 - \$10,000.	
			6	May be 12-36 months or expressed in years	
			7	May be "Income Loss."	
			8	May be 80% - 100%.	
			9	May be deleted.	
	GBD-1200 F27 Edu	<b>Survivor Income Benefit:</b> <i>Will my survivors receive a benefit if I die while receiving Disability Benefits?</i>	1	May be deleted.	
			2	May be deleted.	
			3	May be 12 - 36 months or may be expressed in years or "or have met the Elimination Period" may be added.	
			4	May be deleted or "Benefit" may be substituted or another term may be used depending upon benefit plan.	
			5	May be deleted.	
			6	May be replaced with: "The Survivor Income Benefit will only be paid: 1) to Your Surviving Spouse; or 2) if no Surviving Spouse, in equal shares to Your Surviving Children. If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.	
			7	Item 1 or item 2 may be deleted.	
			8	May be deleted.	

Page #	Module #	Description	Variable #	Description of Variables	Use
			9	May show actual dollar amount or may state: "The Survivor Income Benefit amount is shown in the Schedule." or monthly benefit amount and maximum payment period lanuage may be substituted."	
			10	May be 3 - 12 or optional benefit amount may be shown.	
			11	May be deleted.	
			12	Beneficiary language may be deleted.	
			13	May be deleted.	
			14	Item 2 may be deleted.	
			15	May be 19 - 26 and item #2 may be deleted.	
			16	May be deleted.	
	GBD-1200 F29 Edu	<b>Workplace Modification Benefit:</b> <i>Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?</i>	1	Entire provision may be deleted.	
			2	Entire section may be deleted.	
			3	May be deleted.	
			4	May be \$200 - \$7,500 in \$100 increments.	
			5	May be deleted.	
			6	May be 1, 2 or 3.	
	GBD-1200 F45	<b>Felonious Assault Benefit</b>			
			1	May be deleted or may be "partial" or "Disabled and working" or some other term to meet the specific requirements of the benefit plan.	
			2	May be deleted if there is no waiting period for the Felonious Assault Benefit.	
			3	May be 30 - 180 days.	
			4	May be deleted or may be "partial" or "Disabled and working" or some other term to meet the specific requirements of the benefit plan.	
			5	Item 1, item 2 and/or item 3 may be deleted.	
			6	May be 48 - 96 hours	
			7	May be deleted or may be "partial" or "Disabled and working" or some other term to meet the specific requirements of the benefit plan.	
			8	May be deleted, or state the benefit amount, or use other terminology to meet the specific requirements of the benefit plan.	
			9	May be "the Insured Person's immediate family"; or "the Insured Person's extended family" or some other term to meet the specific requirements of the benefit plan.	
			10	May be "the Insured Person resides" or some other term to meet the specific requirements of the benefit plan.	
			11	Item 3 may be deleted.	
	GBD-1200 F46	<b>Occupational/Non-Disabling Felonious Assault Benefit</b>			
			1	May be deleted.	

Page #	Module #	Description	Variable #	Description of Variables	Use
			2	May be deleted.	
			3	May be deleted; or may be part-time or some other term to meet the specific requirements of the benefit plan.	
			4	May be deleted; or may be "usual and customary" or some other term to meet the specific requirements of the benefit plan.	
			5	May be deleted.	
			6	May be deleted.	
			7	May be deleted.	
			8	May be deleted.	
			9	May be deleted.	
			10	May be deleted.	
			11	Item 1, item 2 and/or item 3 may be deleted.	
			12	May be 48 - 96 hours.	
			13	May be deleted, or state the benefit amount, or use other terminology to meet the specific requirements of the benefit plan	
			14	May be "the Insured Person's immediate family"; or "the Insured Person's extended family" or some other term to meet the specific requirements of the benefit plan.	
			15	May be "the Insured Person resides" or some other term to meet the specific requirements of the benefit plan.	
			16	Item 3 may be deleted.	
	GBD-1200 F47	<b>Medical Premium Supplement Benefit</b>			
			1	May be deleted.	
			2	May be deleted.	
			3	May be deleted.	
			4	May be deleted.	
			5	May be deleted.	
			6	May be deleted.	
			7	May be deleted.	
			8	May be deleted.	
			9	May be deleted.	
			10	Item 1 may be deleted.	
			11	May be \$400 - \$1,200.	
			12	May be deleted.	
			13	May be deleted.	
			14	May be deleted.	
			15	Item 2 may be deleted.	
			16	May be 12 - 30 months.	
			17	Item 3 may be deleted.	
			18	Item 4 may be deleted.	
			19	May be deleted.	

Page #	Module #	Description	Variable #	Description of Variables	Use
			20	May be deleted.	
			21	May be deleted	
			22	Item 7 may be deleted.	
			23	May be deleted.	
			24	May be deleted.	
			25	May be deleted.	
			26	May be deleted.	
			27	May be deleted.	
			28	May be deleted.	
			29	May be deleted.	
			30	May be deleted.	
			31	May be deleted.	
			32	May be deleted.	

[Schedule of Insurance

1

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered Injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

**The benefits described herein are those in effect as of [DATE].**

**Cost of coverage:**

You [must/do not] contribute toward the cost of coverage.

**Eligible Class(es) for Coverage:** All [Full-time] [and Part-time] Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time	[at least # hours weekly]
Employment:	
Part-time	[at least # hours weekly [, but less than # hours
Employment:	weekly]]

[Annual Enrollment Period: [MONTH & DAY] through [MONTH & DAY]/[As determined by Your Employer on a yearly basis]]

**[Maximum Monthly Benefit:** [\$[XXXXXXXX]] ]

**[Guaranteed Issue Amount:** [\$[XXXXXXXX]] ]

**[Minimum Monthly Benefit:** [[X] % of the Monthly Benefit before the deduction of Other Income Benefits.] [the greater of:

1. \$[X] or
2. [X]% of the Monthly Benefit before the deduction of Other Income Benefits].]

**[Initial Benefit Period Percentage:**

Option 1: [X]%  
Option 2: [X]%

**Continuing Benefit Period Percentage:**

Option 1: [X]% of Pre-Disability Earnings  
Option 2: [X]% of Pre-Disability Earnings]

**Eligibility Waiting Period for Coverage:**

Option 1: [X] day(s) - if You are working for the Employer on The Policy Effective Date; or  
Option 2: [X] day(s) - if You start working for the Employer after The Policy Effective Date.]  
[You will be eligible for coverage on the first day of the month on or next following the date on which You complete the Eligibility Waiting Period for Coverage.]

[The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer in an eligible class under the Prior Policy.]

**Elimination Period:**

[For Disability caused by injury, benefits commence on the [X] consecutive day of Disability]  
[For Disability caused by sickness, benefits commence on the [X] consecutive day of Disability]  
[For Disability caused by sickness or injury, benefits commence on the [X] consecutive day of Disability.]

[For Elimination Periods of [30] days or less, benefits commence on the first day of hospital confinement for hospital confinements of 24 hours or more.] ]

[Schedule of Insurance

1

[For Disability caused by [Injury][Sickness][Injury and Sickness]:]

[Maximum Duration of Benefits Table

<b>Age When Disabled</b>	<b>Benefits Payable</b>
Prior to Age 62	To Age 65, or for 48 months, if greater
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months]

[For Disability caused by [Injury][Sickness][Injury and Sickness]:]

[Maximum Duration of Benefits Table

<b>Age When Disabled</b>	<b>Benefits Payable</b>
Prior to Age 65	60 months
Age 65-69	To Age 70, but not less than 12 months
Age 69 and over	12 months]]

]

Any Occupation	means any occupation for which You are qualified by education, training or experience [and that has an earnings potential greater than [the Maximum Monthly Benefit] [the lesser of:	1, 2
	1) [the product of Your Indexed Pre-Disability Earnings] and the Benefit Percentage [and 80]%; or]	3
	2) [the Maximum Monthly Benefit]].	4
		5
		6

GBD-1200 C05 Edu

<b>[Current [Monthly/Weekly] Earnings</b>	means [Monthly/Weekly] earnings You receive from:	1, 2
	1) [the Employer; and	3, 4
	2) other employment;]	
	while You are Disabled [and eligible for the Disabled and Working Benefit.]	5
	[However, if the other employment is a job You held in addition to Your job with the Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly/Weekly] Earnings.]	6 7 8
	[Current [Monthly/Weekly] Earnings also includes the pay You could have received for another job or a modified job if:	9, 10
	1) such job was offered to You by the Employer, or another employer, and You refused the offer; and	
	2) the requirements of the position were consistent with:	
	a) Your education, training and experience; and	
	b) Your capabilities as medically substantiated by Your Physician.]	
	[Current [Monthly/Weekly] Earnings do not include earnings from work performed prior to the Date of Disability.]]	11, 12

**Calculation  
of Monthly  
Benefit:**

**Return to  
Work**

**Incentive:**

*How are my  
Disability  
benefits  
calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 12 consecutive months by deducting Other Income Benefits from the Maximum Benefit.

Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

- 1) the day You first start work; or
- 2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit by deducting Other Income Benefits and Your Current Monthly Earnings from the Maximum Monthly Benefit. The result is Your Monthly Benefit.

**Termination  
of Benefit  
Payment:**

*When will my  
benefit  
payments  
end?*

Benefit payments will stop on the earliest of:

- 1) the date You are no longer Disabled;
- 2) the date You fail to furnish Proof of Loss;
- 3) [the date You are no longer under the Regular Care of a Physician [, unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You]; ] 1, 2
- 4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;] 3
- 5) the date of Your death;
- 6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;] 4
- 7) [the last day benefits are payable according to the Maximum Duration of Benefits Table or;] 5
- 8) [the date Your Current Monthly Earnings exceed: 6
  - a) [80]% of Your [Indexed] Pre-Disability Earnings if You are receiving benefits for being Disabled from Your Occupation [or a Reasonable Alternative]; or 7, 8
  - b) [80]% of Your Indexed Pre-Disability Earnings if You are receiving benefits for being Disabled from Any Occupation;] 9
- 9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;
- 10) [the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try: 11
  - a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
  - b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
  - c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
  - d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;]provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation;] or
- 11) [the date You receive retirement benefits from any employer's Retirement plan, unless: 12
  - a) You were receiving them prior to becoming Disabled; or
  - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]

**Family Care Credit**  
**Benefit:** *What if I must incur expenses for Family Care Services in order to participate in Rehabilitation?*

If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

- 1) Family Care means the care or supervision of:
  - a) Your children under age [13]; or 1
  - b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
- 2) the Maximum Monthly deduction allowed for each qualifying child or family member is:
  - a) [\$200] during the first [6] months of Rehabilitation; and 2, 3
  - b) [\$X] thereafter; 4
 but in no event may the deduction exceed the amount of Your Current Monthly Earnings;
- 3) Family Care Credits may not exceed a total of [\$2,500] during a calendar year; 5
- 4) the deduction will be reduced proportionally for periods of less than a month;
- 5) the charges for Family Care must be documented by a receipt from the caregiver;
- 6) the credit will cease on the first to occur of the following:
  - a) You are no longer in a Rehabilitation program; or
  - b) Family Care Credits for [12] months have been deducted during Your Disability; and 6
- 7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly [Benefit]. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed [80%] of Your [Indexed] Pre-Disability Earnings. 7  
 8, 9

<b>Survivor Income Benefit:</b> <i>Will my survivors receive a benefit if I die while receiving Disability Benefits?</i>	1
If You were receiving a Monthly [Disability] Benefit at the time of Your death [and You had been receiving such benefits [for at least 12 months]], We will	2, 3
pay a [Survivor Income Benefit] when We receive proof satisfactory to Us:	4
1) of Your death; and	
2) that the person claiming the benefit is entitled to it.	
[We must receive the satisfactory proof for Survivor Income Benefits within 1	5
year of the date of Your death.]	
 [We will pay the Survivor Income Benefit:	6
1) [to the beneficiary You designated; or	7
2) if no beneficiary has been designated:]	
a) to Your Surviving Spouse; or	
b) if no Surviving Spouse, in equal shares to Your Surviving Children;	
c) [if no Surviving Spouse or Surviving Children, to Your estate.]]	8
 However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.	
 [The Survivor Income Benefit is calculated as [3] times the [Maximum] Monthly	9, 10, 11
Benefit.]	
 [To designate or change Your designation of beneficiary, You must file a	12
written notice with Us on any form satisfactory to Us. Whether You are living	
or not, any change will relate back and take effect as of the date You signed	
the written notice. We are not liable for payment of benefits made before	
receiving written notice.]	
 <b>Surviving Spouse</b> means Your wife or husband who was not legally	
separated or divorced from You when You died. ["Spouse" will include Your	13
domestic partner, provided You have executed a Domestic Partner Affidavit	
acceptable to Us, establishing that You and Your partner are domestic	
partners for purposes of this Policy. You will continue to be considered	
domestic partners provided You continue to meet the requirements described	
in the Domestic Partner Affidavit.]	
 <b>Surviving Children</b> means Your unmarried children, step children, legally	
adopted children who, on the date You die, are primarily dependent on You for	
support and maintenance [and who are:	
1) under age 19; or	
2) [between the ages of age [19 and 23], inclusive, and in full-time	14, 15
attendance at an institution of learning].	
 The term Surviving Children will also include any other children related to You	
by blood or marriage [or domestic partnership] and who:	16
1) lived with You in a regular parent-child relationship; and	
2) were eligible to be claimed as dependents on Your federal income tax	
return for the last tax year prior to Your death.	
 If a minor child is entitled to benefits, We may, at Our option, make benefit	
payments to the person caring for and supporting the child until a legal	
guardian is appointed.	

**[Workplace  
Modification**

**Benefit:** *Will the  
Rehabilitation  
program provide for  
modifications to my  
workplace to  
accommodate my  
return to work?*

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee.

1

You qualify for this benefit if:

- 1) Your Disability is covered by this Policy;
- 2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
- 3) We approve, in writing, any proposed Workplace Modifications.

[Benefits paid for such workplace modification shall not exceed [the lesser of:

2, 3

- 1) [\$X]; or]

4

- 2) [[1,2,3] times Your Maximum Monthly Benefit, before any deduction for Other Income Benefits.]]

5, 6

We have the right, at Our expense, to have You examined or evaluated by:

- 1) a Physician or other health care professional; or
- 2) a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

- 1) the proposed modifications made on Your behalf are complete;
- 2) We have been provided written proof of the expenses incurred to provide such modification; and
- 3) You have returned to work as an Active Employee.

**Workplace Modification** means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this Policy.]

<b>Felonious Assault Benefit:</b>	If You [or Your Spouse] become [Totally] Disabled as the result of a Felonious Assault which occurs while covered under The Policy, We will pay an additional Felonious Assault Benefit. This benefit will be paid:	1
<i>When is the Felonious Assault Benefit payable?</i>	<ol style="list-style-type: none"> <li>1) [following the greater of a [60] day waiting period or the [Total] Disability Benefit Waiting Period;]</li> <li>2) in a lump sum.</li> </ol>	2, 3, 4
	For the purposes of this benefit, the term Felonious Assault means an act which:	
	<ol style="list-style-type: none"> <li>1) [is an attempt to cause bodily injury; or</li> <li>2) purposely, knowingly, and recklessly causes bodily injury; or</li> <li>3) negligently causes bodily injury with a deadly weapon;]</li> </ol>	5
	and is directed at You [or Your Spouse] during the course of a robbery, kidnapping or other criminal assault.	
	Such assault must be reported to police and filed in a police report within [72] hours of the act and You [or Your Spouse] must become [Totally] Disabled as a result of the assault.	6, 7
	[The specific amount(s) for this benefit are shown in the Schedule of Insurance.]	8
	This benefit will not pay for an Injury that results from a Felonious Assault committed by:	
	<ol style="list-style-type: none"> <li>1) a member of [the Insured Person's family;]</li> <li>2) a member of the household in which [the Insured Person lives];</li> <li>3) [the Insured Person's fellow [Employee]].</li> </ol>	9 10 11

<b>[Occupational] [Non-Disabling] Felonious Assault Benefit:</b>	If You sustain an Injury:	1, 2
<i>When is the</i>	1) as a result of a Felonious Assault which occurs while covered under The Policy; and	
<i>[Occupational] [Non-Disabling] Felonious Assault Benefit payable?</i>	2) as an [Employee] engaged [Full-time] in Your [normal and customary] occupation during:	3, 4
	a) regularly scheduled working hours; [or	5, 6
	b) a required period of work not coinciding with regular work hours;]	7
	[or	8
	c) while in transit to or from work],	
	We will pay an additional [Occupational] [Non-Disabling] Felonious Assault Benefit. This benefit will be paid in a lump sum.	9, 10
	For the purposes of this benefit, the term Felonious Assault means an act which:	
	1) [is an attempt to cause bodily injury; or	11
	2) purposely, knowingly, and recklessly causes bodily injury; or	
	3) negligently causes bodily injury with a deadly weapon;]	
	and is directed at You during the course of a robbery, kidnapping or other criminal assault.	
	Such assault must be reported to police and filed in a police report within [72] hours of the act.	12
	[The specific amount(s) for this benefit are shown in the Schedule of Insurance.]	13
	This benefit will not pay for an Injury that results from a Felonious Assault committed by:	
	1) a member of [the Insured Person's family;]	14
	2) a member of the household in which [the Insured Person lives];	15
	3) [the Insured Person's fellow [Employee]].	16

**Medical Premium Supplement Benefit:**  
*Does The Policy also cover premium contributions for continuance of Medical coverage?*

If You:	
1) become Disabled while You are covered under this Medical Premium Supplement Benefit;	
2) are receiving a Monthly Benefit under The Policy; and	
3) [have experienced a COBRA qualifying event and have elected COBRA continuance of [Your Employer's] Medical Plan] [are an active participant in [Your Employer's] Medical Plan] on the date You become Disabled and incur out-of-pocket expenses as a result of Your election to continue coverage under that Medical Plan;	1 2
4) have not had a lapse in Your [COBRA coverage] [coverage under [Your Employer's]] Medical Plan during the elimination period; and	3, 4
5) are not eligible for Medicare,	
We must pay a [Monthly] [semi-monthly] Medical Premium Supplement Benefit to [You] [[Your Employer] on Your behalf.] The Medical Premium Supplement Benefit will be [the lesser of]:	5, 6, 7 8, 9
1) [\$[X] per month] [;or]	10, 11, 12
2) the actual amount of premium You pay to [Your Employer] to continue coverage [under Your Medical Plan] [pursuant to COBRA].	13, 14

You will cease to receive a Medical Premium Supplement Benefit when:	
1) You cease to be Disabled; [or]	15
2) You have received payments under this benefit for [X months;]]	16
3) [Your coverage under [Your Employer's] Medical Plan ends due to Your failure to pay premiums for that coverage;]	17
4) [COBRA continuance under [Your Employer's] Medical Plan ends for any reason;]	18
5) You fail to provide satisfactory proof [on a quarterly basis] that You are making premium payments to [Your Employer] for [COBRA] continuation of Your Medical Plan;	19 20
6) You obtain coverage for Yourself [or Your dependents] under another group Medical Plan; [or]	21 22
7) The Policy terminates].	

**COBRA** means the Consolidated Omnibus Reconciliation Act of 1985, as amended, including changes made by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

<b>Medical Plan</b> means a program that:	
1) provides health insurance or medical coverage to Your [and Your dependents]; and	23
2) for which You are eligible as a result of employer with [the Employer].	

Medical Plan does not include:	
1) [coverage for Your dependents];	24
2) accident-only or disability income insurance;	
3) [limited scope,] [dental,] [vision,] benefits];	25, 26, 27, 28
4) long term care/nursing home care/home health care coverage or any combination thereof;	
5) Medicare supplemental coverage;	
6) Specified disease coverage;	
7) Hospital confinement indemnity insurance; or	
8) Other similar types of insurance coverage designed to provide limited, incidental or supplemental benefits.	

[Payment of the Medical Premium Supplement Benefit will not result in any reduction of Your Monthly Benefit.] [If the sum of Your Monthly Benefit, Current Monthly Earnings, if You are not receiving benefits under the Return to Work Incentive, and the Medical Premium Supplement Benefits exceeds 100% of Your [Indexed] Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess.] [However, Your	29 30 31 32
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Monthly Benefit will not be less than the Minimum Monthly Benefit.]

This benefit is subject to all other applicable terms and conditions of The Policy.

If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Medical Premium Supplement Benefit for each day You were Disabled.

GBD-1200 F47



April 20, 2009

Arkansas Insurance Department  
Life and Health Division  
1200 West Third Street  
Little Rock, AR 72201

Faristine Moore  
Compliance Analyst  
GBD Compliance

Hartford Life Insurance Company  
NAIC #: 88072 FEIN #: 06-0974148

PLEASE NOTE: An identical filing was submitted for Hartford Life and Accident Insurance Company

RE: New Submission Group Disability Insurance  
**GBD-1200 B.4 Edu et al.** **Certificate Enhancements**

Dear Sir or Madam:

We are submitting the enclosed modules for general use with our Certificate Form GBD-1200 A.1 et al. previously approved by your Department on November 5, 2003. A list of modules included in this filing is enclosed for your convenience.

The modules include revisions of language previously filed and approved by your department as well as ten modules describing new definitions or benefits. These modules do not replace any modules currently on file with your department.

**EMPLOYER MARKET**

**GBD-1200 B.4 Edu (Schedule of Insurance)** – This new module includes information pertaining to eligibility, benefits, Guaranteed Issue and the Elimination Period as well as Benefit Tables.

**GBD-1200 C05 Edu (Any Occupation)** – This new module includes the definition of “Any Occupation”.

**GBD-1200 C09 (Rev.) ([Current Monthly/Weekly] Earnings)** – This module has been revised to include the last sentence.

**GBD-1200 F12 Edu (Calculation of Monthly Benefit: Return to Work Incentive)** – The criteria for the Calculation of Monthly Benefit are included in this new module as well as information about the Return to Work Incentive.

**GBD-1200 F18 Edu (Termination of Benefit Payment)** – This new module contains a detailed explanation of the situations or events resulting in the Termination of Benefit Payment.

Hartford Life  
200 Hopmeadow Street  
Simsbury, CT 06089

Mailing Address:  
Hartford Life  
P.O. Box 2999  
Hartford, CT 06104-2999

**GBD-1200 F25 Edu (Family Care Credit Benefit)** – An explanation of the Family Care Credit Benefit and how the benefit is calculated are included in this new module.

**GBD-1200 F27 Edu (Survivor Income Benefit)** – This new module includes a detailed explanation of the Survivor Income Benefit and definitions of “Surviving Spouse” and “Surviving Children”.

**GBD-1200 F29 Edu (Workplace Modification Benefit)** – The definition of and qualifications for Workplace Modification Benefit are contained in this module.

**GBD-1200 F47 (Medical Premium Supplement Benefit)** – This is a new benefit and the module includes a detailed benefit description and a comprehensive definition of “Medical Plan”.

### **ASSOCIATION/AFFINITY MARKET**

**GBD-1200 F45 (Felony Assault Benefit)** – This is a new benefit and the module includes a definition of “Felony Assault” and the requirements for qualifying for the benefit.

**GBD-1200 F46 ([Occupational] [Non-Disabling] Felony Assault Benefit)** – This is a new benefit and the module includes a definition of “Felony Assault” and the requirements for qualifying for the benefit.

**Domiciliary state approval.** The enclosed modules have been submitted to our domiciliary state of Connecticut and were approved on January 7, 2009.

**Variability.** The variable material is set off by brackets, to indicate it may be added to, deleted from or changed. A Statement of Variable Language is enclosed with this filing.

**Filing Fees** The required filing fee of \$50.00 is being submitted via EFT.

If you have any questions or comments, please do not hesitate to call collect to leave a message for me with Yolanda Topps at 860-843-8259. If it would be more convenient to fax or email your comments, my fax number is 860-843-3608 and my email address is Faristine.Moore@hartfordlife.com.

Thank you for your review of this filing.

Sincerely,



Faristine Moore  
Compliance Analyst  
GBD Compliance

Hartford Life  
200 Hopmeadow Street  
Simsbury, CT 06089

Mailing Address:  
Hartford Life  
P.O. Box 2999  
Hartford, CT 06104-2999

	<b>List of Modules</b>
<b>Module #</b>	<b>Description</b>
GBD-1200 B.4 Edu	Schedule of Insurance
GBD-1200 C05 Edu	Any Occupation
GBD-1200 C09 (Rev.)	Current Monthly/Weekly Earnings
GBD-1200 F12 Edu	Calculation of Monthly Benefit: Return to Work Incentive
GBD-1200 F18 Edu	Termination of Benefit Payment
GBD-1200 F25 Edu	Family Care Credit Benefit
GBD-1200 F27 Edu	Survivor Income Benefit
GBD-1200 F29 Edu	Workplace Modification Benefit
GBD-1200 F45	Felonious Assault Benefit
GBD-1200 F46	Occupational/Non-Disabling Felonious Assault Benefit
GBD-1200 F47	Medical Premium Supplement Benefit